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THE RHODE ISLAND MEDICAL JOURNAL



Owned and Published by the Rhode Island Medical Society. Issued Monthly

VOLUME II } Whole No. 119
NUMBER 5 }

PROVIDENCE, R. I., MAY, 1918

PER YEAR \$2.00
SINGLE COPY 25 CENTS

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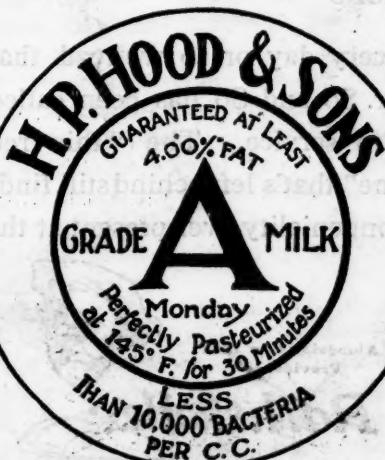
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ORIGINAL ARTICLES

EYE STRAIN AS RELATED TO GENERAL PRACTICE.*

By FRANK J. McCABE, M. D.,
Providence, R. I.

It is not without some hesitancy that I appear before you this evening to discuss the old, hackneyed and, to some of you, perhaps, uninteresting subject of eye strain or asthenopia. However, I shall ask your indulgence for a few brief minutes to remind you of facts which, because you have so many other things to keep in mind, you have long ago forgotten.

Some one has said that in modern medicine the keystone in diagnosis and treatment is "co-operation;" therefore the excuse for this contribution is an effort to direct the attention of the general practitioner to a field of real helpfulness on the part of the ophthalmologist.

By eye strain, or asthenopia, is meant a fatigue or weakness of the eyes with its resultant accompanying symptoms. For purposes of differential diagnosis, study and treatment the following types are recognized:

- (1) Accommodative, due to errors of refraction and to strain of the ciliary muscle.
- (2) Muscular, due to an abnormal condition of the extrinsic muscles of the eye.
- (3) Nervous, due to some faulty condition of the nervous system; *reflex*, due to abnormalities in the organism outside of the eye and the nervous system.

In discussing these different types of asthenopia, it would be well to refresh our memories by reviewing briefly the anatomy and physiology of the ocular system as it relates to eye strain.

The function of the eye and its appendages is to receive impressions of objects in space and to transmit those impressions to the brain for interpretation. These impressions are produced

by a stimulation of the retina by that form of energy which we call light. The ciliary muscle, or muscle of accommodation, is in almost constant activity during waking hours in its effort to clarify retinal images. This activity is particularly marked in the hyperopic or far-sighted eye, where no retinal image is clearly defined except through the action of the ciliary muscle. Myopic or near-sighted people cannot aid vision by ciliary activity, and consequently practically all retinal images in myopes are blurred. It is recognized that nearly 95 per cent. of all persons have more or less astigmatism, i. e. irregularity in the curvature of the refractive media, producing irregularly shaped retinal images, which are extremely irritating to the retina itself and also to the cerebral centers of interpretation. Low hyperopic errors are easily overcome by action of the ciliary muscles, and the effort to see better, being stimulated by fair vision, it results in muscular fatigue or hypertrophy, or both; so that a patient with 20/15 vision, which is better than the average normal vision, may be suffering greatly from eye strain; whereas in high errors of refraction, the ciliary muscle soon learns that it cannot overcome the defect, and the poor vision which results is associated with blurred images, of irregular diffusion, which persist in irritating the retina. As the great majority of both hyperopic and myopic eyes are complicated with astigmatism, we can readily see that in most cases we are dealing with a combined effect of muscular fatigue and retinal irritation.

Twelve muscles are required to balance the two eyes, so that all images will fall on corresponding retinal areas and thus maintain binocular vision. When one or more of these muscles are weaker than the others, the sense of fusion requires it to keep up with the stronger muscles in the effort to maintain binocular single vision, thereby calling forth an abnormally large amount of nerve force to these weaker muscles.

It is evident, therefore, that the reasons for eye strain are fatigue, hypertrophy, and congestion of the ciliary muscles in the constant effort

*Read before The Providence Medical Association, April 1, 1918

to produce clear vision; retinal irritation from circles of diffusion, made worse by the irregularity in the presence of astigmatism; and extrinsic muscular hypertrophy and fatigue in the struggle to maintain binocular single vision.

Of the cranial nerves, the second, third, fourth and sixth are devoted wholly to the eye and its appendages, while the fifth is concerned with sensory functions. The second or optic, after entering the orbit, and piercing the scleral and chorioidal coats of the globe, expands to form the retina. Its function is purely visual in that it transmits to the cerebral centres of vision the exact impressions made upon the retina, through the refractive media of the eye. The third nerve, or motor oculi, sends voluntary motor fibres to all the extrinsic ocular muscles, except the superior oblique and the external rectus. While passing through the cavernous sinus, it receives a few sensory fibres from the ophthalmic division of the fifth nerve and a definite anastomosis from the cavernous plexus of the sympathetic. The branch of the third nerve, which supplies the inferior oblique muscle, gives off a twig, which is the motor root of the lenticular ganglion.

The fourth nerve is the motor nerve of the superior oblique muscle, and, like the third nerve, has an anastomosis with the sympathetic from the cavernous plexus, and also receives sensory fibres from the first or ophthalmic branch of the fifth nerve.

The sixth nerve supplies the external rectus muscle and receives its sympathetic fibres from the carotid plexus. The first division of the fifth nerve, which is given off from the Gasserian ganglion, is purely sensory and is called the ophthalmic nerve. It receives sympathetic fibres from the cavernous plexus and has three branches: (1) the lacrymal, which enters the lacrymal gland and anastomoses with the orbital branch of the superior maxillary and with the facial nerves; (2) the frontal, divides into the supartrocLEAR and the supra orbital, and is distributed to the forehead, eyelids and scalp, and communicates with the infratrocLEAR and the facial nerves; (3) the nasal has several branches: those of importance in this discussion are the ganglionic, which enter the lenticular or ciliary ganglion to form its sensory root, and the long ciliary nerves (2 or 3) which pierce the sclera near the optic nerve and pass forward in the eyeball to be distributed to the ciliary muscle and iris. The nasal also sends sensory fibres to the

conjunctiva, caruncle, lacrymal gland, the upper lid, forehead and the root of the nose and also to the nasal septum and turbinates and to the tip of the nose.

The ciliary ganglion has three roots,—a motor, from the motor oculi nerve; a sensory, from the nasal branch of the first division of the fifth, and a sympathetic root, from the cavernous plexus. The ciliary ganglion gives off ten or twelve short ciliary nerves, which pass forward through the sclera and the choroid and are distributed to the iris and ciliary muscles.

The sympathetic system consists of two great gangliated cords extending the whole length of the vertebral column. The two cords are connected above with two plexuses which enter the cranium and unite with the fifth cranial nerves; below, they are joined together in a loop over the coccyx. Each ganglion has an afferent and an efferent connection with the anterior division of the corresponding spinal nerve. This extensive system, through its ganglia and series of plexuses, provides a switchboard connection between the various organs, and it is supposed that a sympathetic relation is thus maintained between different organs. The chief functions of the sympathetic nerves are vaso-motor, trophic, secretory and control of smooth or involuntary muscles. Thus it can be easily seen what close relations there are between the motor and sensory supply of the ocular mechanism and the sympathetic system.

The most common form of asthenopia is the accommodative, and in all cases this must be ruled out before the other types can be diagnosed. We are told that nearly every child is born hyperopic (i. e., far sighted), due to a small, short eye with more or less flat surfaces. As the child grows and uses his eyes, they gradually elongate and the surfaces become more convex, until at a certain time we may get an emmetropic or normal dioptric apparatus; or it may elongate too much, then we get myopia or near sightedness. This is the case among those who use their eyes a great deal for near work. It is said to be a sign of civilization, as savages and lower animals are nearly all far sighted.

One of the most difficult things to understand in the study of the effect of errors of refraction upon the human organism is the widely varying results produced by the same error upon different individuals. Many eyes are very tolerant; most people have demonstrable errors of refraction of

which they are unconscious; many of those who become conscious of such errors remain comfortable when the spectacle frame becomes bent, when a spherical glass is tilted so as to produce an astigmatic effect, or when the axis of a cylindrical lens is altered several degrees, and such patients may obtain satisfaction from anything like a fair approximation to their true correction.

This fact has had great weight in perpetuating the idea that accuracy in the fitting of glasses is not of such great importance after all. But many eyes are intolerant to even a very slight error of refraction, or to a little variation of the correcting lens from its proper position. Patients with such eyes are apt to complain of headache, not associated with any symptoms which can be termed distinctly ocular, can be persuaded with difficulty to have their eyes examined at all, and yet are often completely relieved by a very weak glass, especially if the error is astigmatic. As you all know, the most common symptom of eye strain is headache, which may be frontal, occipital or temporal, and usually appears after close work. It is said that eighty per cent. of all headaches are due to eye strain. Many years ago, Weir Mitchell pointed out that "asthenopia may be revealed solely by occipital or frontal headache, there being no pain in or about the eyes and no sense of fatigue locally, but if such strain be allowed to continue for a long time, it may cause insomnia, vertigo, nausea and general ill-health." The pain may be frontal, ranging all over the forehead, or bitemporal, or it may be worse in the occipital or vertical regions. Other symptoms are pain, fatigue, burning and smarting of the eyes, blurring of the vision, feeling of sand in the eyes, lacrymation, photophobia, fibrillary tremor of the orbicularis, twitching, migraine, digestive disturbances and nervousness.

As a result of asthenopia, we often see conjunctivitis, blepharitis, styes, chalazia, also a congestion of the retina and choroid.

In a fairly large minority of cases of eye strain, the symptoms are due to an unbalance of the extrinsic muscles of the eye. However, its presence can be demonstrated in many persons who have no symptoms of asthenopia, and also in many who have asthenopia from other causes. In such cases, the imbalance must be compensated for physiologically, or it must be physiological, according to Roemer, else it is itself a symptom of some other abnormal condition, in which case attention must be paid to the under-

lying causes. In many such cases we are dealing with tendencies to inco-ordination accompanied by ocular symptoms of unbalanced nerve action rather than with demonstrable lesions of the muscular or nervous systems; therefore, every condition of the organism which may disturb the nervous equilibrium, whether in the eye or not, should be investigated, and its bearing on the individual case studied. An imbalance of the muscles frequently passes away, or is physiologically compensated for, when the glasses that correct an error of refraction are constantly worn, and it is well known that both mental and physical factors affect the nervous equilibrium and thereby the balance of the muscles. Besides these cases, there remains a goodly number in which the imbalance is not symptomatic and is not compensated for, but is a primary condition, productive of trouble which needs correction.

The intimate relations which exist between the eye and all other parts of the body cannot be emphasized too strongly. The connection between the eye and a viscous situated in the abdomen, through the nervous, circulatory and lymphatic systems, is just as close as that between any other two separate organs, i. e., the eye reacts to troubles situated in distant parts, and other organs react to troubles in the eye. Persons suffering from overwork, worry, anemia or general debility, who complain of eye strain, show the result of a general nervous irritation.

Nervous asthenopia may be a symptom of a grave nervous disease. Reber of Philadelphia reported a case in which asthenopia seems to have been the *first* symptom of tabes, with the reflex immobility of the pupil the next. This type of eye strain is frequently found in so-called cases of neurasthenia and in hysteria. O'Connor describes a number of such cases which were quickly and permanently relieved by the proper fitting of glasses.

Sometimes we can trace the etiology of an asthenopia to an irritative or an inflammatory condition in one or more of the abdominal organs or to an abnormal condition in the nose or accessory sinuses, and also in some cases of menstrual disorders, and in renal disease.

The physician not infrequently is confronted with the difficult problem of determining the active underlying cause of a given condition which he is called upon to treat. It is not an easy matter to establish a definite causal relation

in every case; especially is this true of conditions that are to be attributed to some remote reflex irritation. The so-called functional disorders of the gastro-intestinal tract, when no organic changes can be recognized, in the absence of acute or chronic inflammation, must be considered of reflex origin and not infrequently the visual apparatus may be the offending organ.

Irritability of the stomach, loss of appetite, dyspeptic symptoms after the ingestion of food, regardless of the nature of the food, dizziness, nausea and vomiting are often caused by eye strain.

Dizziness, as a symptom of some ocular defect, is very common, and is frequently attributed, by the patient as well as by the attending physician, to some gastric disturbance, there being no ocular symptoms present. This form of dizziness is always aggravated by an overloaded stomach, which condition, if continued, calls for local treatment, dietetic as well as medicinal, but to effect a cure the ocular defect must be corrected. Nausea as a result of some eye disturbance is not an infrequent condition; it is observed in many of the inflammatory conditions of the eye, such as iritis and glaucoma, and also in cases of errors of refraction and in muscular imbalance.

Nausea is very often followed by vomiting and is usually associated with vertigo. Persistent vomiting may be caused by errors of refraction, especially of the mixed astigmatic type. The symptoms often may be of such a severe nature as to simulate a cerebral lesion. Gastro-intestinal symptoms of ocular origin are especially observed in children during the period of school life; these children suffer from headache, dizziness, nausea and vomiting and are compelled to lose valuable time on this account. In such cases, it is extremely difficult to convince parents that their children need glasses, especially as the children state that they can see perfectly well.

Mechanical pressure in the nose, where a turbinate presses upon the septum, is often a cause of ocular symptoms, even when the patient states that he has absolutely no trouble with his nose. Correction of the difficulty gives great relief.

In concluding, I wish to emphasize one important point, namely: when symptoms of malfunction of one organ or system persist after treatment of all obvious disorders, it is not fair to ascribe the condition to nervousness, hysteria, idiosyncracy or what not, or even to call it

obscure, until the function of every other organ has been studied and corrected. The constant use of the eyes during waking hours, and the demand for and frequently great waste of nerve force in their use, call for a careful ocular correction in all cases of functional disorder, possibly due to some reflex irritation.

With your permission, I wish to cite the following cases which I have seen recently:

CASE 1. T. P., a husky looking young man, who complained of severe headache, dizziness, and vomiting after each meal, regardless of what he ate. He had been treated by three physicians, but his stomach symptoms did not improve. He was referred to me to see if he needed glasses. Examination showed no heterophoria, external eye negative and fundi, fuzzy, but nothing pathological, vision 15/30 o. u. Refraction under a cycloplegia showed mixed astigmatism. Glasses were ordered and patient told to return in two weeks; he stated on his return that he had not vomited for more than a week and was able to eat anything without distress.

CASE 2. M. H., age 22 years, clerk. Has had severe pain in and about eyes for nearly two years, also frontal headache, sometimes so severe that he was obliged to give up work for the day. Had several pairs of glasses, but without much relief. Muscle test showed him to have a right hyperphoria of 3 degrees (right eye tended to deviate upward) combined with hyperopic astigmatism. Appropriate glasses for his asthenopia with prisms (right base down, left base up 1 degree) gave him immediate relief.

CASE 3. M. B., girl, 17 years, student. Her mother stated that the girl had not been well for two or three years; that she had nervous indigestion, etc. The girl was irritable, remained by herself a good deal of the time; was so nervous that she wept in school frequently. Refraction with appropriate glasses cleared up her indigestion and made her a happy, congenial girl.

CASE 4. E. C., boy, 10 years old. Was in class for backward children. Teachers told his mother that his mind was not "developed enough for him to learn in school." His mother said that he was bright enough at doing everything but his school work. Refraction followed by appropriate glasses improved his mental development to such an extent that within three months he was put into the grades and, according to his teacher, he seemed to learn as well as any of the other children.

A REVIEW OF ONE HUNDRED CONSECUTIVE CASES OF ACUTE DISEASES OF THE APPENDIX, GALL BLADDER, DUODENAL AND GASTRIC ULCERS WHICH HAVE COME TO OPERATION.*

By FREDERICK V. HUSSEY, M. D.,
Providence, R. I.

On looking over the records of the cases on which this paper is based, I have been very much impressed with what seems to me to be a serious failure of the general physician in the treatment of many cases of appendiceal and gall bladder disease and ulcer of the stomach and duodenum. The general surgeon is in a very good position to determine the results of preliminary medical treatment in acute conditions of the stomach, duodenum, gall bladder and appendix; he sees the conditions at the time of operation and knows the exact state of affairs which exists. I think in most instances the fault lies, not in the man's lack of knowledge, but in his lack of courage—his reluctance to advise radical measures in the beginning, without first trying out some of the older methods of treatment, which brings his patient into an extreme condition. This reluctance, of course, oftentimes is promoted by the patient's desire to avoid operation, if possible, and only to submit to it when the trouble has become so serious as to make every other method of treatment out of the question. An operation should be used simply as a means to an end, and it should be advised at the time it promises the best results. It should never be postponed, without very good reason, until it has become a method of last resort, if we hope to obtain the results that we should in this class of acute cases.

In going over these one hundred histories, the figures I have been able to obtain are not as satisfactory as I had hoped they would be, owing to the fact that many important points in the histories were not brought out. This has often been due to the negligence of inexperienced men, young internes, who have taken the histories and who have not been awake to the importance of eliciting certain symptoms leading up to the acute condition, and as a consequence there is a great lack of detail in some cases as to the exact condition and exact sequence of symptoms

covering a considerable length of time previous to the acute illness for which they were admitted to the hospital for treatment.

Of the hundred cases selected, there were 76 cases of acute and 2 cases of sub acute appendicitis, 16 cases of acute gall bladder disease, 5 cases of acute perforated gastric ulcer, and 1 case of acute perforated duodenal ulcer. Of the 78 cases of appendicitis, 23 were of the acute catarrhal type; 22 of these were operated on with no mortality; 2 refused operation and went home well from the attack. None of these cases were drained, and the average time in the hospital for each case was about 12 days. There were 46 cases of acute gangrenous appendicitis, all of which were drained, and of which 3 died, giving a mortality of 6½ per cent. There were 7 cases of the acute suppurative type, with drainage, and no mortality; and 2 cases of the sub acute type, and no mortality. The average length of time in the hospital for each drained case was in the neighborhood of three weeks. According to the records, 37 of the 78 cases had had one previous acute attack, and 20 of them had had more than one, and these attacks had been spread over a time varying from one week to eleven years. I feel that the number of cases reported as having had one or more previous attacks is smaller than it should be, as some of the histories very plainly did not take up that point. Many of the patients had been given cathartics of various kinds early in the attacks. The day of the attack on which the patient was admitted to the hospital varied from the first to the twenty-first, the average being the fourth day. The excess of time in the hospital of the 53 drained cases over what it should have been had they been clean was approximately 530 days, or about 10 days to each case.

Now, what do the above figures mean? Let us first sum up what is considered to be the most efficacious method of treatment of these acute cases. First, rest in bed; second, starvation diet; third, no catharsis; fourth, ice locally; and fifth, as soon as the diagnosis can be made, operate, unless there are very clear contra indications. It has been the experience of practically all surgeons that this line of treatment has been the cause of the tremendous drop in the mortality of acute appendicitis in the last ten years. After operation in conjunction with the Fowler position, the Murphy saline drip has been very efficacious in drained cases following operation.

Four points stand out very plainly from the figures quoted; first, the large number of cases having had previous acute attacks or previous symptoms of chronic inflammation; second, the frequent use of catharsis in the initial stages; third, the comparatively late day of the sickness on which they were admitted to the hospital for operation; and fourth, the much longer stay in the hospital of the drained cases over the clean.

It would seem that, in spite of all that has been written, the lesson has not been well learned. Undoubtedly some cases refuse operation during the first attack, or they may have wished to delay operation until the seriousness was all too obvious; but, on the other hand, was a conscientious attempt always made by the physician to make the patient see the seriousness of the trouble from the very beginning? Were not some carried along by palliative measures, in the hope that the attack would subside, and operation be avoided, until it was too late to have a clean operation? In other words, do not many of us to-day fail to impress on our patients the seriousness of the condition, both as regards the present attack and the risk of those to come? Also, are we alive to the frequency of chronic appendiceal trouble as the cause of long standing indigestion, which finally breaks out in the typical acute attack? All of this sounds old, yet I daresay the truth of it will be borne out by reference to the records of any general hospital. Again, many physicians continue to physic their patients at the beginning of any acute abdominal condition without first having made a sound and accurate diagnosis, and, in many instances, even after a diagnosis has been made. This is a method of treatment which cannot be defended in the light of the experience of the best men. It undoubtedly has had much to do with the aggravation of symptoms in many cases and their progression to a much worse condition. Also, we find that instead of getting these patients into the hospital for an early operation when conditions are most favorable for a clean operation, they are being admitted fairly late, when drainage is necessary, with a rather long, tedious, painful convalescence, with conditions more favorable for such complications as secondary abscess formation, obstruction from adhesions, paralytic ileus from peritonitis, and so forth. We find that the drained cases are detained much longer in the hospital and are much longer in getting back on their feet after leaving the hospital than the

clean cases. This last point is of considerable economic value. The laboring man is subjected to greater hardship and the expense for care of the patient in the hospital is greatly increased. It seems to me there is a great loss of time and money due to our failure, in many instances, to take a firm stand at the beginning.

Of gall bladder cases there were 16; 7 were cases of acute cholecystitis with gall stones; 1 of acute cholecystitis without gall stones. There were 5 cases of empyema with gall stones and 1 of empyema without gall stones; there were 2 cases of gall stones with symptoms of sub acute cholecystitis; 13 cases were operated on with a mortality of 5; 2 died from causes which could not be controlled, 1 from pulmonary embolus, 1 from intestinal hemorrhages when about to leave the hospital, and which at autopsy were shown to have come from an ulcerated condition of the ascending and transverse colon. The other three cases that died were cases of severe empyema in which only a simple cholecystostomy and drainage had been done. Of the 16 cases, 12 had previous symptoms, either in the form of acute attacks of colic or long standing indigestion. In 4, no history of previous trouble was obtained. Only in 3 was there jaundice. The duration of the symptoms varied from three weeks to twenty years.

Here, again, the outstanding feature was the length of time these cases had been allowed to drag along, frequently presenting symptoms of their condition and yet not coming to operation until in the midst of a serious acute attack, when an operation was rather imperative and the time most unfavorable. All of the cases showed symptoms enough to make a diagnosis of their condition before the acute attack for which they were operated. If the time for operation had been chosen during some previous quiescent period, it is only fair to presume that the mortality would have been very much lower than it was—23 per cent.—excluding the two cases that died from extraneous causes. Here again the most pronounced feature was the failure of the physician to grasp the seriousness of the condition and the tendency to delay until disaster actually occurred.

Of the cases of ulcer there were six—five of gastric ulcer and one duodenal. The five cases of acute perforated gastric ulcer were operated on, with one death following a secondary operation for gastric fistula which formed after the

first operation for closure of the ulcer and drainage.

Death occurred in the perforated duodenal ulcer which was not operated on because of the patient being in a moribund condition at the time of admittance to the hospital. There was a mortality of 20 per cent. in the operated cases and 33 1-3 per cent. in all. Five cases gave a definite history of previous trouble, and the duration was from three weeks to eight years. Here again we have a failure to make a definite diagnosis and to advise proper treatment.

In stomach, gall bladder and duodenal trouble there still seems to be a tendency among many of us to treat the symptoms of indigestion or dyspepsia without grasping the fact that any long continued or recurring indigestion has some underlying organic cause for its existence. There is still the failure to use all our means of diagnosis to clear up the situation, and if in spite of it all we cannot then make a definite diagnosis, there is still the hesitancy to advise an exploratory operation in these long standing conditions.

We know that the normal rate of mortality in operations for appendicitis should be practically nil when done at the most favorable time, and that in diseases of the gall bladder and ulcers of the stomach and duodenum it should not be much over 3 to 4 per cent. If we will only take a more determined stand, get at the bottom of the trouble and not only advise but insist on appropriate treatment before our cases get into such a condition that we are obliged to operate on them when the risk is greatest, we will be able to save many of them that we now lose. The trouble is not with the operation, and it is not that many of these cases are unusually sick, but it is that we allow them to get into a serious condition before we send them in for operation; it is that we delay appropriate measures until what is essentially a safe method becomes an unsafe one because of the progression of the disease. If we know that early operation will save more patients, why not insist on it when any particular case is in its early stages? If the few figures I have given above mean anything or carry a lesson to us, it is that delay and not operation has killed many patients and in many others has caused a long, painful convalescence with unsatisfactory after results.

IN MEMORIAM.

CAPT. PETER L. KEOUGH, M. D., M. R. C., U. S. ARMY.

The medical profession of Rhode Island has suffered its first war casualty in the untimely death of Dr. Peter L. Keough of Pawtucket. Dr. Keough was commissioned a Lieutenant in the Medical Officers' Reserve Corps shortly after our entrance into the war and soon won his Captaincy. While on duty at Camp Sherman, Chillicothe, Ohio, he contracted pneumonia, which rapidly proved fatal on April 15.

The profession mourns his death and extends to the bereaved wife and family heartfelt sympathy. His sacrifice of home ties, of profession and, supreme to all, his life for his country's service is at once an inspiration and a grief to us all. May the consciousness of his patriotic service well done be balm to those who mourn his passing. For him

"The strife is o'er, the battle done,
The victory of life is won."

WAR DEPARTMENT.

OFFICE OF THE SURGEON GENERAL.
WASHINGTON.

1. Attention of medical officers is directed to the provisions of paragraph 423, M. M. D.—"Medical officers will not publish professional papers requiring reference to official records or to experience gained in the discharge of their duties without the previous authority of the Surgeon General."

2. Numerous scientific papers written by officers of the Medical Department have recently appeared in the medical press without specific authority from this office. This practice will be discontinued, and the above regulation will be strictly complied with.

3. Officers desiring publication of professional papers will submit two copies to the Surgeon General with request for permission to publish same. Upon approval, a copy will be forwarded to the journal designated by the officer for publication.

By direction of the Surgeon General:

C. L. FURBUSH,
Lieutenant Colonel, Medical Corps, N. A.

THE RHODE ISLAND MEDICAL JOURNAL

Owned and Published by the Rhode Island Medical Society
Issued Monthly under the direction of the Publication Committee

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Advertising matter must be received by the 15th of the month preceding date of issue.

Advertising rates furnished upon application, to the business manager, J. F. Hawkins, M.D., 114 Westminster Street, Providence, R. I.

SUBSCRIPTION PRICE, \$2.00 PER ANNUM. SINGLE COPIES, 25 CENTS.
Entered at Providence, R. I. Post Office as Second-class Matter.

RHODE ISLAND MEDICAL SOCIETY

Meets the first Thursday in September, December, March and June

JOHN CHAMPLIN	President	Westerly
GARDNER T. SWARTS	1st Vice-President	Providence
JOHN M. PETERS	2d Vice-President	Providence
JAMES W. LEECH	Secretary	Providence
W. A. RISK	Treasurer	Providence

DISTRICT SOCIETIES

KENT		
Meets the second Thursday in each month		
H. BARTON BRYER	President	Natick
JAMES M. BODWELL	Secretary	Phenix
NEWPORT		
Meets the third Thursday in each month		
EDWARD V. MURPHY	President	Newport
A. CHACE SANFORD	Secretary	Newport

PAWTUCKET		
Meets the third Thursday in each month excepting July and August		
ARTHUR H. MERDINYAN	President	Central Falls
CONRAD E. THIBODEAU	Secretary	Pawtucket
PROVIDENCE		
Meets the first Monday in each month excepting July, August and September		
WILLIAM F. FLANAGAN	President	Providence
CHARLES O. COOKE	Secretary	Providence
WASHINGTON		
Meets the second Thursday in January, April, July and October		
A. B. BRIGGS	President	Ashaway
W. A. HILLARD	Secretary	Westerly
WOONSOCKET		
Meets the second Thursday in each month excepting July and August		
EDWARD L. MYERS	President	Woonsocket
E. F. HAMLIN	Secretary	Slatersville

Section on Surgery—2d Wednesday in each month, Dr. F. G. Phillips, Chairman Dr. Peter P. Chase, Secretary and Treasurer.
Section on Diseases of Children—3d Tuesday in each month, Dr. Henry E. Utter, Chairman; Dr. J. S. Kelley, Secretary and Treasurer.

Section on Gynecology and Obstetrics—3d Wednesday in each month, Dr. C. W. Higgins, Chairman; Dr. E. S. Brackett, Secretary and Treasurer.

Section on Medicine—4th Tuesday in each month, Dr. D. Frank Gray, Chairman; Dr. C. W. Skelton, Secretary and Treasurer.

R. I. Ophthalmological and Otological Society—2d Thursday—October, December, February, April and Annual at call of President, Dr. Harlan P. Abbott, President; Dr. C. J. Astle, Secretary-Treasurer.

NOTICE

The House of Delegates having voted that the dues shall be \$10.00 for 1918, the Treasurer desires to call the members' attention to Article IV Sec. 6 of the By-Laws: "Every Fellow shall annually contribute the Annual dues and the same shall be due and payable to the Treasurer, January first of each year."

EDITORIALS

RHODE ISLAND AND THE MEDICAL RESERVE CORPS.

Attention has recently been called in the public press to the fact that the quota of Rhode Island physicians who have enlisted in the Medical Reserve Corps is lamentably small. It is a sad commentary that a state which has exceeded its quota in the Working Reserve, and which has stood commendably near the top in Liberty Loan and Red Cross drives, should fall to the forty-second place in such an important branch of the service as the Medical Reserve Corps. We are

unwilling to believe that this unenviable position near the foot of the class comes from any lack of patriotism in the medical profession of this state, nor from a fear that on their return from service they will find their practices dissipated and their families facing starvation. It is due rather to a failure to appreciate the fact that unless this country puts forth every ounce of its strength in all lines of endeavor, we shall be forced by a German victory to pay an indemnity beside which our present income taxes and Liberty Loan subscriptions would pale into insignificance. Another reason for failure of our physicians to enlist is to be found in the unfortunate announcement of the Adjutant General several months ago that no more commissions would be issued in the Medical Reserve Corps. It has been stated time and again that the order was issued simply to allow the office force time to catch up with its work. Corrections never receive the attention which is given to previous incorrect statements, and the idea still persists that there is no further need of physicians at present. The Surgeon General states in a letter on another page of this issue that 15,000 medical officers will be needed for an army of 1,500,000. If our army is recruited up to 4,000,000 or 5,000,000, as seems likely, it will be necessary to ask for a great many more medical men.

In commenting upon the small quota of physicians enlisted in this state, it is only fair to the profession to point out that the Rhode Island Hospital Unit contains eighteen men enlisted in the Naval Reserve Force, who would be credited to the Army Reserve Corps but for the fact that the Government requested this unit to organize as a Navy rather than an Army unit. Even so small a number as eighteen raises the percentage quite appreciably in a state where the total quota asked for is only about one hundred.

MEDICAL FACTS AND THEORIES.

The articles appearing in the *Providence Journal* under the caption Medical Facts and Theories besides being very interesting have had an educational value in combatting the preposterous claims of quackery, and proving how absurd were the statements made regarding the efficacy of widely advertised proprietary medicines.

The high esteem in which the author is held not only by the profession of the State and country but by the laity carries weight which could

not be borne by a man of less ability or one who was not so well known.

The *Providence Journal* is to be highly commended for its courageous stand regarding the advertising of proprietary medicines and comparatively few advertisements which are evidently misleading appear in its columns.

We believe, however, that the author of Medical Facts and Theories slightly oversteps the proper boundaries when, as in the issue of April 13, he indicates by name any man actively engaged in the practice of medicine in the State of Rhode Island. Certainly he does not wish to advertise the ability of one man at the expense of his fellow practitioners or to suggest that sufferers from any disease should consult a certain man to the exclusion of others. Yet the article in question has already influenced patients to change their medical advisor and will undoubtedly affect the practice of men amply qualified to care for this class of patients. It would have been as fair in the article on Infantile Paralysis to have said that sufferers from this disease should consult some one neurologist or orthopedic surgeon, and we are quite sure that the author did not intend to draw any invidious comparison. Yet to the laity it would appear that the names mentioned were the names of the only physicians capable of caring for tuberculosis patients.

THE END OF FRIEDMANN.

By chance, two medical journals lay, side by side, on our desk. In one was an account written by Dr. Barnes, of the end-results of Friedmann's treatment of tuberculous patients at Wallum Lake. The end-results, needless to remark, show that the loudly-vaunted vaccine had no beneficial effects whatsoever. In the other journal was the obituary of Lieutenant-Colonel John McCrae, who gave his life in devotion to the men, all of them like himself, fighting for civilization in Flanders. Here, we thought, is material for a study in contrasts which should appeal especially to us in Rhode Island, since we were actively concerned in the Friedmann business.

And the contrast—what is it? Simply this—the contrast between two opposite principles bodied forth in living flesh and blood: the principle of egoism concealed behind the outward trappings of suave talk and oily promises, and the principle of altruism, the other name of which is renunciation. Briefly, we describe them thus—

the principle of give and the principle of take. McCrae was a master of the first, Friedmann of the second. Coming amongst us with much blatant sound and fury, Friedmann signifies—nothing! Going from our midst in silence to his death, McCrae signifies—everything! And whom will you cherish in your memories? the man who capitalized—we say it advisedly—capitalized human pain and misery and sorrow, who took much and gave in return nothing, or the man who said and *meant* what he said.

"If ye break faith with us who die
We shall not sleep, though poppies grow
In Flanders Fields."

To ask the question is to answer it. Quite so, and yet we ask it; for the standing menace of our profession is the commercial spirit, while its constant support is the spirit of McCrae. Observe, we do not say the making of money in medicine is a menace, because that may be, as it usually is, but the honorable reward of labor honorably done; we say the commercial spirit, that vile, barbaric thing which is now covering with blood the fair face of Europe and setting every man at another's throat. This thing we saw at work in Friedmann, and long after his exit with his pockets lined with gold, we gaze upon its results, so eloquently damned in the simple words of Dr. Barnes, "it appears certain that the vaccine had no beneficial effect upon the patients." McCrae we shall always revere as a brave and chivalrous gentleman. On Friedmann let us finally lower the curtain of oblivion forever.

HELP THE FOOD ADMINISTRATION.

We physicians should consider ourselves unofficially officers of the United States Food Administration. As family advisers in matters of health we can explain to our patients the letter and spirit and intent of the restrictions now laid upon the public, and we can clear away many false notions which appear to have arisen in the minds particularly of those whose attention more than normally centers on the activities of their organs of digestion. We can assure the normal man that less meat, wheat, and sugar in his diet will be to his advantage; we can convince the fat man that meat fat, butter, oils and bread should for him be reduced to a minimum, and we can persuade the hypochondriac that the change from wheat bread to fifty per cent. barley,

rice or potato bread has nothing to do with those eructations of "gas" or that "terrible distress" after eating. Furthermore, we can grant special dispensations to the real invalids whose future health may depend on the successful assimilation of food, and in whom the choosing of easily digestible, non-irritating articles of diet with a maximum nutritional value is the prime necessity. We are, or should be, expert dietitians, and we should make ourselves thoroughly familiar with the aims and activities of the Food Administration and energetically active in furthering its work.

THE RHODE ISLAND HOSPITAL UNIT TO MOBILIZE.

Navy Base Hospital No. 4, which was organized under the auspices of the Rhode Island Hospital about a year ago, has been notified that it will be mobilized in the near future. This announcement will serve to end a period of suspense which has lasted for many months, and which has been trying for the staff, the nurses and the enlisted personnel. The number of Navy Base Hospital units is small as compared with those of the Army, and at present there are but six organized. Several of these are now seeing active duty in important places. The Providence unit has been organized and its complete equipment in readiness for many months. Commander Carpenter, U. S. N., who has been stationed at the Naval Hospital, Newport, has been appointed the executive and commanding officer of the unit. Commander Carpenter will be remembered by those who attended the September meeting of the Rhode Island Medical Society, held at the Rhode Island Hospital, as the author of an interesting paper on the present medical activities in this Naval District.

CALL TO THE FRONT.

The war is disturbing and upsetting so many things in our lives which we thought were immutable, that medical journals cannot expect to escape the drag net. The business manager of the RHODE ISLAND MEDICAL JOURNAL has responded to the call of duty and has recently departed for service at Fort Oglethorpe. Doctor Hawkins will be greatly missed in a position which he has filled with great ability. When the Providence Medical Journal was in a precarious

condition he took over its business management and worked with untiring energy until it was placed upon a sound financial basis. When this journal was replaced by the present state journal and became a monthly instead of a bi-monthly publication, the amount of work and detail which fell upon the business manager was enormous. The physicians of the state are greatly indebted to Doctor Hawkins for his able services cheerfully given in an unenviable position.

ILLEGAL OPERATORS.

A medico-legal item of interest occurred last month when a woman was convicted in the local court of illegal operation. The woman had enjoyed a lucrative clientele for some time, pursuing her nefarious work in a respectable residential section of Providence. Especial interest attaches to the case by reason of the fact that, so far as we know, this is the first case of a woman convicted in this State for the crime of performing abortion, and, furthermore, that the conviction did not depend upon the death of the unfortunate patient. The police, by their clever management of the affair by which the culprits were caught red-handed and without opportunity to prepare more than the flimsiest of alibis, and the Attorney General's office, by the promptitude and vigor with which the case was prosecuted, are to be heartily congratulated. It is a service rendered whose far-reaching possibilities in breaking up this iniquitous practice cannot be overestimated and decent public opinion cannot fail to approve of the outcome.

SOCIETIES

RHODE ISLAND MEDICAL SOCIETY.

SECTION IN MEDICINE.

A meeting of the Section in Medicine of the Rhode Island Medical Society was held at the Medical Library, April 23, 1918, at 8:45 p. m.

Paper: "Pernicious Anemia." Dr. Charles A. McDonald.

CREIGHTON W. SKELTON, M. D.,
Secretary-Treasurer.

DISTRICT SOCIETIES

PROVIDENCE MEDICAL ASSOCIATION.

The regular monthly meeting of the Providence Medical Association was held at the Medi-

cal Library on April 1, 1918. The meeting was called to order by the President, Dr. William F. Flanagan, at 8:55 p. m. In the absence of the Secretary, Dr. F. M. Adams was appointed Secretary pro tem. There were present at the meeting forty-five members. The records of the preceding meeting were read and approved.

The first paper of the evening, entitled "Eye Strain as Related to General Practice," was read by Dr. Frank J. McCabe.

The discussion was opened by Dr. W. C. McLoughlin, who discussed the relationship between headache, gastric disturbances and ocular strain, many such cases giving no history of symptoms referable to the eyes. The discussion was continued by Dr. Leech, who emphasized the relationship between body symptoms, headache and eye strain. He also discussed the intimate relationship of the eye and the nasal accessory sinuses. He also discussed the troubles occurring in the old or presbyopic stage, remarking the difficulty which the patients have in obtaining relief and the necessity of making careful fundus examinations. Dr. Hawkins cited a case of constipation cured by the use of properly fitted glasses.

The second paper, entitled "A Review of One Hundred Consecutive Cases of Acute Diseases of the Appendix, Gall Bladder, Duodenal and Gastric Ulcers Which Have Come to Operation," was read by Dr. Frederic V. Hussey.

The paper was discussed by Dr. John W. Keefe, who feels that analysis of surgical records should be studied for morbidity and mortality results. He cited his experience in appendicitis covering a period of years, showing the attitude in former years. The physician should advise early operation, firmly advising quick action. Cathartics in abdominal diseases are contra indicated. In gall bladder disease, operation should be deferred until acute symptoms subside.

Dr. O'Meara called attention to the resolution before the Senate for appropriations by the State to the Rhode Island and St. Joseph's Hospitals, urging upon the members the importance of using their influence to have these measures passed.

Dr. John M. Peters told of the efforts of the Rhode Island Hospital to get help from the towns outside of Providence.

Dr. Flanagan thanked Dr. O'Meara for his efforts in medical legislation and urged upon the members of the Association the importance of

influencing the members of the legislature. The meeting adjourned at 10:20 p. m. A collation was served.

FRANK M. ADAMS, *Secretary pro tem.*

KENT COUNTY MEDICAL SOCIETY.

Regular meeting of the Kent County Medical Society was held in the rooms of the Nurse Association at Riverpoint, March 21, 1918, at 4 p. m., Dr. Bryer in the chair. Minutes of the last meeting read and approved. Bills for printing, postage, etc., were approved and ordered paid. The Owen Bill, 3748, and the Dyer Bill, 9563, creating advance rank for officers of the Medical Corps, were read to the Society, approved, and a resolution to that effect ordered sent to senators and representatives from this State. Dr. Frank E. Peckham of Providence read a paper—illustrated by X-ray pictures and films—on "Fractures in General," and showed splints and appliances tried by him and found practical. Vote of thanks extended to Dr. Peckham. Voted to adjourn.

JAMES M. BODWELL, *Secretary.*

NEWPORT DISTRICT SOCIETY.

At the deferred annual meeting of the Newport Medical Society, held March 21, 1918, the following officers were elected for the ensuing year: President—Dr. Edward V. Murphy; First Vice President, Dr. Abram F. Squire; Second Vice President—Dr. Charles W. Stewart; Secretary—Dr. A. Chace Sanford; Treasurer, Dr. D. P. A. Jacoby; Delegates to the House of Delegates of the Rhode Island Medical Society—Drs. Norman MacLeod and Marcus F. Wheatland; Censors—Drs. S. C. Powell, William S. Sherman and Henry V. Carroll. The matter of electing a Councillor was left until the next meeting.

A. CHACE SANFORD, *Secretary.*

PAWTUCKET MEDICAL ASSOCIATION.

The twenty-third annual meeting of the Pawtucket Medical Association was held March 21, 1918, at the To Kalon Club, Pawtucket. The following officers were elected: President—Dr. A. H. Mardinyan; Vice President—Dr. E. J. Mathewson; Secretary—Dr. C. E. Thibodeau; Treasurer—Dr. S. A. Hughes; Member of the Standing Committee for five years—Dr. C. H. Holt; Delegates to the House of Delegates of the Rhode Island Medical Society—Drs. H. A. Manchester and E. S. Kiley.

The business meeting and election was followed by a dinner, after which the members listened to an address by Commander D. N. Carpenter, U. S. N., who spoke on the work of the Medical Corps in the Navy.

The regular monthly meeting of the Pawtucket Medical Association was held in the out-patient building of the Memorial Hospital, April 18, 1918, at 8:45 p. m. Dr. Charles O. Cooke of Providence read a paper entitled "Acute Diseases of the Abdomen."

CONRAD E. THIBODEAU, *Secretary.*

WOONSOCKET DISTRICT SOCIETY.

The regular meeting of the Woonsocket District Medical Society was held March 21, 1918, at 8:30 o'clock, at the office of Dr. E. D. Clarke. A general discussion took place concerning the society, and medical matters in general. Much interest was manifested by the members, and there was a good attendance. The next meeting will be held with Dr. J. J. Baxter, April 18, 1918.

E. F. HAMLIN, *Secretary.*

HOSPITALS

RHODE ISLAND HOSPITAL.

Dr. L. S. Gilpatrick has gone to the Providence Lying-In Hospital to remain on duty until the mobilization of the Navy Base Hospital No. 4, to which he is attached.

Dr. H. J. Gallagher is on duty at the Providence Lying-In Hospital while awaiting orders.

Dr. T. C. Wyman has been commissioned 1st Lieutenant, M. R. C., and has been ordered to the Army Medical School at Washington.

The regular quarterly meeting of the Rhode Island Hospital Staff Association was held in the chapel at the hospital, April 8, 1918, at 12 m.

PROVIDENCE CITY HOSPITAL.

Dr. Frederick Thorne began his service as interne on March 15, 1918.

Dr. Morrissey began his service on March 1, 1918.

Dr. Parker Mills has been appointed Second Assistant Superintendent and began his duties April 1, 1918.

LETTER TO THE EDITOR.

MEDICAL RESERVE CORPS.

To the Editor:

1. I wish to call to the attention of the profession at large the urgent need of additional medical officers. As the war progresses the need for additional officers becomes each day more and more apparent. Although the medical profession of the country has responded as has no other profession, future response must be greater and greater. The Department has almost reached the limit of medical officers available for assignment.

2. I am, therefore, appealing to you to bring to the attention of the profession at large the necessity for additional volunteers. So far the United States has been involved only in the preparatory phase of this war. We are now about to enter upon the active, or the fighting phase, a phase which will make enormous demands upon the resources of the country. The conservation of these resources, especially that of man-power, depends entirely upon an adequate medical service. The morning papers publish a statement that by the end of the year a million and a half of men will be in France. Fifteen thousand medical officers will be required for that army alone. There are today on active duty 15,174 officers of the Medical Reserve Corps.

3. Within the next two or three months the second draft will be made, to be followed by other drafts, each of which will require its proportionate number of medical officers. There are at this time on the available list of the Reserve Corps, an insufficient number of officers to meet the demands of this draft.

4. I cannot emphasize too strongly the supreme demand for medical officers. Will you give the Department your assistance in obtaining these officers? It is not now a question of a few hundred medical men volunteering for service, but it is a question of the mobilization of the profession that in the large centers of population and at other convenient points as well as at all Army camps and cantonments, boards of officers have been convened for the purpose of examining candidates for commission in the Medical Reserve Corps of the Army. An applicant for the Reserve should apply to the board nearest his home.

5. The requirements for commission in the Medical Reserve Corps are that the applicant be a male citizen of the United States, a graduate

of a reputable school of medicine, authorized to confer the degree of M. D., between the ages of 22 and 55 years of age, and professionally, morally and physically qualified for service.

6. With deep appreciation of any service you may be able to render the Department, I am

W. C. GORGAS,
Surgeon General, U. S. Army.

MISCELLANEOUS

Dr. Peter L. Keough of Pawtucket, Captain in the M. R. C., U. S. A., and stationed at Camp Sherman, Ohio, died April 15, 1918, after a short illness of pneumonia.

Capt. Joseph F. Hawkins of Providence and Capt. Fenwick G. Taggart of East Greenwich, M. R. C., U. S. A., left April 8 for duty at Fort Oglethorpe, Georgia.

ARSPHENAMINE AND NEOARSPHENAMINE.

In view of the reports in current medical literature of untoward results from the use of arsphenamine and neoarsphenamine, the United States Public Health Service requests that samples of any lots of these arsenicals which have shown undue toxicity should be forwarded to the Hygienic Laboratory for examination.

In sending these samples it should be ascertained that the lot number is the same as that of the ampoules used on patients. The samples sent should, if possible, be accompanied by a brief note stating the approximate body weight and age of the patient, the dose and dilution of the drug given, the symptoms and result; that is, whether fatal or not.

AMERICAN MEDICAL ASSOCIATION.

HOTEL HEADQUARTERS FOR THE CHICAGO SESSION.

The following hotels have been tentatively designated as general and section headquarters for the Chicago Session, June 10 to 14:

General Headquarters: Hotel Sherman, North Clark and West Randolph.

Practice of Medicine: Hotel Morrison, 83 West Madison.

Surgery, General and Abdominal: Auditorium Hotel, 430 South Michigan.

Obstetrics, Gynecology and Abdominal Surgery: Congress Hotel, South Michigan and Congress.

Ophthalmology: Hotel LaSalle, LaSalle and West Madison.

Laryngology, Otology and Rhinology: Hotel LaSalle, LaSalle and West Madison.

Diseases of Children: Congress Hotel, South Michigan and Congress.

Pharmacology and Therapeutics: Auditorium Hotel, 430 South Michigan.

Pathology and Physiology: Auditorium Hotel, 430 South Michigan.

Stomatology: Congress Hotel, South Michigan and Congress.

Nervous and Mental Diseases: Blackstone Hotel, South Michigan and East Seventh.

Dermatology: Blackstone Hotel, South Michigan and East Seventh.

Preventive Medicine and Public Health: Auditorium Hotel, 430 South Michigan.

Genito-Urinary Diseases: Auditorium Hotel, 430 South Michigan.

Orthopedic Surgery: Congress Hotel, South Michigan and Congress.

Gastro-Enterology and Proctology: Auditorium Hotel, 430 South Michigan.

Scientific Exhibit, Registration Bureau, Commercial Exhibit, Information Bureau, and Branch Postoffice: Hotel Sherman, North Clark and West Randolph.

BOOK REVIEWS

TECHNIC OF THE CARREL METHOD. By J. DUMAS and ANNE CARREL. pp. 90. Paul B. Hoeber, New York. \$1.25.

This little brochure is an authorized translation by Dr. Adrian V. S. Lambert of the French original, and the translation is an excellent one. This book in no way supplants the more complete account by Carrel and Dehelly on "The Treatment of Infected Wounds." It was written primarily for the information of nurses so that they might have a clear, short account of the various details of the technic and an accurate description of the apparatus used in carrying it out. In terse, crisp language accurate and definite directions are given as to the various steps in this method of treating infected wounds. The materials used in the dressing, microscopical examination of the wound secretions, the nature of the dressing and of the irrigating apparatus, the technic of irrigation and of the preparation of Dakin's solution are carefully and briefly de-

scribed in separate chapters. To one who has witnessed the demonstration of the Carrel method in the special war hospital at the Rockefeller Institute, it is apparent that the book is well written for the purpose in mind. It will be of great value to those who would familiarize themselves with the technic of the method. The theoretical discussion of wound infection, case reports and surgical problems relating to infection find no place, of course, in such a work as this.

R. H.

IMPOTENCE AND STERILITY, WITH ABERRATION OF THE SEXUAL FUNCTION AND SEX GLAND IMPLANTATION. By G. Frank Lydston, M. D., D. C. L. The Riverton Press, Chicago, Ill. Price \$4.00.

The first chapter emphasizes the bearing that aberration and imperfection of sex have on sexual relations, dealing with hermaphroditism, hypospadias, epispadias and various kinds of acquired defects, both physical and psychical. The book continues with a broad view regarding monogamy and polygamy, the human excesses in an indulgence which nature meant for the propagation of the species only, and a very sharp criticism, which I think is justly warranted, of the profession for its passiveness toward the proper dissemination of sexual knowledge and laxity for prophylaxis for venereal diseases and its vital importance to our social status.

The chapters on impotence and sterility are ably written, the psychical, drug and electrical treatment extremely rational.

The author strongly reiterates his views that sexual perversion and inversion are purely biochemical in origin, that perversion of the quality and lessening of the quantity of sex hormone formed in the glands that produced the parental germ cell or sperm cell, or both, is the biologic foundation of both psychic and physical aberrations of sex differentiation. If this view is correct and cases are taken early, prior to adult age, these are susceptible to cure by implantation of sex glands, thereby adding to the economy during the period of sex development a certain quantity of new and better quality of sex hormone. The last three chapters are devoted to sex gland implantation and the author substantiates his belief in its value and effects by numerous experiments of implantation of testes and ovaries in living subjects.

The book is most ably written and brings before us new possibilities. J. E. K.